TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Spine and Joint Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-17-0735-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the records clearly indicate authorization was provided for the services rendered, making Zurich's denial invalid."

Amount in Dispute: $8,104.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on November 22, 2016. Texas Administrative Code §133.307 (d) (1) states,

> Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As no response was received, this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16, 2015	Outpatient Hospital Services	$8,104.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures applicable to prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 197 – Precertification/authorization/notification absent

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $8,104.00 for outpatient hospital services rendered on November 16, 2015.

   The insurance carrier reduced the disputed services with reduction codes, 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code 134.600(p)(2) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted documentation finds:
   - Zurich Services Corporation document with date November 11, 2015
     - Services Authorized: Pump Check Under Fluroscopy

   Review of the submitted "Pain Management Procedure Report"
   - Synchro Med pump in situ with concern of catheter failure

   Review of the submitted medical claim finds the following procedure:
   - 61070 – "Puncture of shunt tubing or reservoir for aspiration or injection procedure."

   Based on the above, the Division finds the carrier's denial of the submitted code(s) on the medical claim as "not being authorized" is supported.

2. The Division is unable to order payment on the services in dispute as the requirements of Rule 134.600(p)(2) were not met.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 22, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.